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Pandemic Injustice in Mental Health: Quebec's Punitive Turn During COVID-19

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Abstract

In Quebec, the state of emergency due to COVID-19 has substantially changed practices in mental health. Formally, several measures must help contain the spread: hospitalizations are limited and replaced by telephone or video follow-up; visits and outings are prohibited; judicial activities are suspended with the exception of urgent applications like psychiatric assessment, psychiatric commitment and coercive care; and hearings take place over video. However, the idea that people with mental illness would have difficulty accepting and respecting sanitary measures justifies putting in place special precautions based on the possibility of a contamination risk. Observation of practices shows that, in order to manage risk, particularly punitive measures have been put in place, going beyond official directives and for a longer period than measures have lasted in the general population. Study of case law and newspaper articles highlights an abusive use of seclusion and prohibition of visits and outings, a diversion of psychiatric procedures to enforce confinement and distancing measures and significant procedural adjustments impacting people's ability to assert their rights. These risk-based practices not only break with previous law's interpretations, but turns out to be discriminatory, establishing a noticeable difference between the general population, patients hospitalized for physical problems, even COVID-19, and people with mental illness. Quebec's regulation of the COVID-19 pandemic in mental health highlights the limits of law and courts as safeguards of rights as well as the necessity of valuation and consideration of experiential knowledges, recognition of structural discrimination and massive investment in social services to enforce equality and justice.

Pandemic Injustice in Mental Health: Quebec's Punitive Turn During COVID-19

On March 12, 2020, the Premier of Quebec declared a state of emergency to contain the spread of COVID-19; the declaration was then renewed by order-in-council every seven or ten days. At the time of this writing, in mid-November, that state of emergency is still in effect. During this period, the executive branch governed by regulation, decree and order. At the height of the first wave, the city of Montreal was the epicenter of the pandemic in Canada, and the province of Quebec was the place with the seventh highest rate of deaths per capita in the world.

The situation quickly got out of control in long-term care facilities for senior citizens. Several scandals put the spotlight on the devastating effects of the progressive privatization of health services, drastic cuts in social services and structural constraints in a system underfunded by decades of neoliberal policies. The unacceptable situation in these facilities has been extensively discussed, giving rise to class actions, official investigations and public management of residences. Little attention has been paid to the situation in the other places of institutionalization, namely prisons, psychiatric hospitals and group home and assisted-living environments that provide housing for people with mental health issues, addiction or intellectual or physical disabilities. Information about what goes on in these facilities is scarce, incomplete and inconsistent, although several COVID-19 outbreaks have occurred in these types of facilities since the start of the pandemic. It is essential to address the situation in these institutions because of the historical abuses that took place within them, as well as the history of health and non-health crises that shows an erosion of rights and an extension of control and surveillance of marginalized groups (Fitzpatrick, 1994; Foucault, 1977). The COVID-19 pandemic is no exception (Lebret, 2020), including in Canada (Mykhalovskiy et al., 2020).

In the context of Quebec, the management of the actual pandemic in psychiatric hospitals, group homes and assisted-living environments is of particular concern because of the coercive approach to mental illness and treatment that has prevailed for decades. In the early

1960s, Quebec held the sad record for the highest number of psychiatric beds per 100,000 inhabitants and the longest stays in asylums. Approximately 90% of patients at that time were involuntarily hospitalized. During the following decades, despite the measures put in place to deinstitutionalize, Quebec has continued to have more beds in psychiatric wards than both Canadian and world averages (Bernheim, 2014). Involuntary admission came to be rationalized by the best interest of the patients rather than by legal criteria (Brown & Murphy, 2000), and treatments were forced on people with mental illnesses, in hospitals or prisons, in absence of legal provisions (Somerville, 1985).

In the 1990s, the reform of the *Civil Code of Québec* and the *Mental Health Protection Act* raised much hope in matters of the rights and access to justice for people with mental illness. The involuntary admission regime has been fully modified; specific provisions related to forced treatment,[1] as well as the use of seclusion and restraint, are now supervised and monitored. Quebec law appears more protective of rights than the legislation of several countries due to the judicialization, the strictness of the procedural framework and the fact that involuntary admission and forced treatment are subject to two different civil procedures before two different courts. The effectiveness of the law, however, is entirely based on the contractual doctrine of consent and relies on the effective expression of the will, the right to self-determination, the inflexible application of substantive and procedural law, and the systematic use of the courts to force admission and treatment.

Since the beginning of the 2000s, the number of involuntary admissions and forced treatment applications has continued to increase in Quebec.[2] Research and investigations led by academics, advocacy groups, public institutions and journalists brought to light disturbing irregularities in the application of these exceptional measures, within both hospitals and courthouses. Systematic

[1] In many jurisdictions, treatments may be imposed against patients' will through an administrative community treatment order. In Quebec, the equivalent mechanism is an "authorization of care" granted by a court to a physician to allow them to administer treatment despite the refusal expressed by the person or their legal representative.

[2] No provincial statistics indicate the extent to which seclusion and restraint are used.

violations of patients' rights—such as lack of information, failure to obtain consent to care, exceedingly strict time limits, old and incomplete psychiatric reports, absence of defendants at a large percentage of hearings, and court proceeding *ex parte*—are being denounced by a growing number of organizations (Bernheim, 2020). The vagueness of legal criteria such as risk, danger and capacity, as well as the controversial tendency to pit patients' rights against safety, has led some to conclude that the law, and more specifically rights, cannot alter psychiatric practices (Szasz, 2005).

It must be said that the perception that people with mental illness are dangerous has increased since the 1950s despite a lack of scientific data. This perception is more strongly associated with certain illnesses such as schizophrenia, but also with certain socio-demographic characteristics such as gender, race and education level (Parcesepe & Cabassa, 2013). This helps explain, at least in part, why "most countries have decided that dangerousness linked to mental illness justifies preventive interventions" (Applebaum, 2003, p. 441). While few studies explore the social contexts leading to violence (Stuart, 2003; Weller, 1984), research on the correlation between mental illnesses and violence and on risk assessment tools is in full swing. The underlying assumption of this risk-based research is that behaviours can be predicted and changed, making it possible to avoid accidents (Lupton, 2013).

Risk is "posed by the individuals themselves when they cannot adequately manage their life within the community, and the risk these individuals pose to the community on account of their failure to govern themselves" (Rose, 1996, p. 349). In contrast to danger, which must be demonstrated by facts, risk is the interrelationship of multiple imprecise factors that are not necessarily dangerous when considered individually (Castel, 1991; Rose, 1996; Ward, 2016). This lack of a factual basis makes it an essentially normative judgment with little connection to psychological processes (Ward, 2016), and undoubtedly explains the high proportion of assessment errors, as well as the overrepresentation of certain social groups, particularly racialized groups (Douglas et al., 2017), among those considered at risk.

In practice, the risk-based approach involves constant calculation and management of risk in order to control at-risk individuals and ensure security (Rose, 1996, 1998), a phenomenon well described by Michel Foucault (1977, 1999, 2003). In the daily practice of risk-based psychiatry, the focus is on risk assessment and management rather than on care, constant monitoring and coercive practices such as seclusion, locked doors (Slemon, Jenkins & Bungay, 2017), involuntary admission and forced treatment. Professionals have a responsibility to contain risk and are blamed for incidents they could not predict and prevent (Slemon, Jenkins & Bungay, 2017; Ward, 2016). Risk-based psychiatry is controversial due to the unreliability of its assessment tools (Douglas et al., 2017) and to its deleterious effects on access to care (Ryan, Nielssen, Paton & Large, 2010) and patients' rights (Fazel et al., 2012).

In Quebec, research has shown that the risk-based approach is the foundation of hospital and judicial practices (Bernheim, 2019). Based on historical observations of crises, the hypothesis at the genesis of this project is that the pandemic context exacerbates existing trends, which this research confirms. In this paper, I will demonstrate the subordination of the law and the justice system to bureaucratic imperatives, indicating a "punitive turn" (Christie, 1996) in Quebec psychiatric policies.

I will first present the legal framework for mental health in Quebec, as well as the methodological framework of my work. Second, I will describe the Quebec government's official position on pandemic regulation and mental health, as set out in its legal and non-legal publications, and discuss it in light of the scientific literature. Third, I will analyze the implementation of this regulation on the basis of case law and journalistic investigations.

Quebec's Legal Framework for Mental Health: A Rights-based Approach

Quebec's legal framework for mental health underwent an in-depth reform in the early 1990s, in the wake of the reform of the *Civil Code of Québec*. The new *Civil Code* structure demonstrates that, among all juridical personality rights, the integrity of the person is the most

important, which protects individuals against any interference with their body without free and informed consent (section 10). Therapeutic relationships are conceptualized as care contracts governed by classic contractual rules, namely expression of will even against medical advice or a person's best clinical interests. The contractual rules are the cornerstone of rights to integrity and self-determination. The parliamentary debates from the early 1990s clarified that the same principles apply to everyone without discrimination, regardless of state of health or legal status. It is precisely this absence of differentiation in the context of psychiatric assessment, involuntary admission or forced treatment, as well as judicial process, that must protect people with mental illness against the denial of civil and fundamental rights, including freedom (Bernheim, 2014). Seclusion and restraint, which are considered to be "control measures," are subject to the same general provisions and principles. Of these four legal mechanisms, only psychiatric assessment and involuntary admission specifically concern mental health. Forced treatment and control measures are exceptions to general principles, but the documentation of practices over the last 30 years shows that people with mental illness are particularly affected.

Involuntary admission was the subject of public law provisions and a medical decision until the 1990s. Its introduction into the *Civil Code,* in the section on treatment, now makes involuntary admission a civil litigation between doctor and patient which must be decided by a court, following a trial; this also makes it a rights issue rather than a strictly clinical one. The measure is aimed at persons who have not committed an offence but who the court believes are a danger to self or to others owing to their "mental state." No formal psychiatric diagnosis is required, but the danger related to their mental state must be assessed by psychiatrists. Involuntary admission only allows people to be detained, not treated, against their will.

First, hospitals, families or any person can apply to the Court of Quebec, the provincial court, to have a psychiatric assessment ordered. The court can grant the application only if the judge has "serious reasons to believe" that the defendant "is a danger to himself or to others owing to his mental state" (*Civil Code of Québec*, section 27(1)). If two psychiatrists confirm that involuntary admission is

necessary due to the danger to self or others, hospitals have to present a second application. It is up to the plaintiff to demonstrate, through preponderant evidence based on facts, "specific explanations relating to the person involved" (*GT c Centre de santé et de services sociaux du Suroît*, 2010[3] : § 2) and linking the alleged danger to the mental state of defendant. The danger must be significant and specific and must be interpreted restrictively (*JM* c *Hôpital Jean-Talon du Centre intégré universitaire de santé et de services sociaux (CIUSSS) du Nord-de-l'île-de Montréal*, 2018; *A* c *Centre hospitalier de St. Mary*, 2007). The *Civil Code* provides that the court may not order an involuntary admission "unless the court itself has serious reasons to believe that the person is dangerous and that the person's confinement is necessary, whatever evidence may be otherwise presented to the court and even in the absence of any contrary medical opinion" (section 30(2)). The requirement of the court's personal conviction goes beyond the usual civil standard of proof—the balance of probabilities.

Forced treatment was not regulated until the reform of the *Civil Code*. The new provisions draw a clear line between involuntary admission and treatment in that forced treatment is an exception to the general principles of consent to treatment and not a specific legal mechanism for people with mental illness. The legal criteria are also different, and danger is not a factor to be considered for forced treatments (*Institut Philippe de Montréal* c *AG*, 1994). Forced treatment concerns "persons who are incapable of giving their consent" to treatment and who "refuse categorically" to receive treatments "required by their state of health" or whose legal representative "is incapable of giving his consent, is prevented from doing so or, without justification, refuses to do so" (*Civil Code of Québec*, sections 16(1) and 23(2)). The incapacity to consent to treatment is not related to any health condition or legal status. Being involuntarily hospitalized, under guardianship, criminally unfit or not criminally responsible on account of a mental disorder does not affect the capacity to consent to treatment. However, criteria in the test developed by case law to determine capacity to consent to treatment have the effect of linking certain mental illnesses, including the

[3] The case law cited can be found in the list of references.

schizophrenia spectrum and other psychotic disorders, to the incapacity to consent (*Institut Philippe de Montréal* c *AG*, 1994). This jurisprudence has been repeatedly upheld by the Quebec Court of Appeal, contrary to the *Starson* decision rendered by the Supreme Court of Canada in 2003.

To obtain the judicial authorization to treat people against their will, hospitals must present an application to the court of general jurisdiction, the Superior Court of Quebec. They have the burden of proof to demonstrate the patient's incapacity to consent to treatment, that the treatment is required due to the patient's state of health and that the expected benefits outweigh the risks.

For psychiatric assessment, involuntary admission and forced treatment, the procedural framework is particularly strict and rigid. In addition to the right to counsel and to present witnesses granted to any party to a trial, very tight time limits must be respected throughout the procedures. Defendants must be notified personally and "be heard in person for the purpose of making representations, giving their opinion or answering questions" (*Code of Civil Procedure,* section 391(1)). An exemption of testimony may be granted by the court if it is impossible to hear the person, if it is clearly inexpedient to insist on such representations, opinion or testimony being given because of the urgency of the situation or the person's state of health, or if it is shown to the court that requiring that the person testify could be harmful to the person's health or safety or that of other persons (*Code of Civil Procedure*, section 391(2)).

Judgments may be appealed as of right (*Code of Civil Procedure*, section 30(1)). In civil matters, the procedure is generally applied flexibly, and judgment may be rendered by default against a defendant who fails to appear in court. Several types of judgments can only be appealed with leave. The specificity of the procedural framework demonstrates the exceptional nature of this legal mechanism, as well as the importance of the protection of rights at all stages of the process.

Control measures, though highly controversial, were not subject to any legislative framework until the 1990s. The use of isolation and restraints is associated with suicides, choking on restraint equipment, respiratory and cardiac arrest due to the use of force, hallucinations, anxiety, distress and recollection of past traumatic events (Barnett, Stirling & Pandyan, 2012; Fabris & Aubrecht, 2014; Holmes, Murray & Knack, 2015). Research has shown that their use is more frequent for young, male, psychotic and immigrant patients (Jarrett, Bowers & Simpson, 2008; Knutzen et al., 2011). The new provisions aim to reduce the use of control measures through alternative measures, adequate conditions of use, staff training and monitoring. The use of seclusion and physical and chemical restraint must be minimal and exceptional, only "to prevent the person from inflicting harm upon himself or others" (*Act respecting health services and social services*, section 118.1), and only in the context of "imminent risk" (Ministry of Health and Social Services, 2015, p. 9). Control measures can be used in two contexts: planned and unplanned intervention. In the context of a planned intervention, the use of control measures appears in the treatment plan and is the subject of free and informed consent. The unplanned intervention is implemented without a patient's consent, or despite a patient's refusal, to manage an urgent, unexpected and risky situation. Although consent is not required, full information on the use of the measures must be given. In both cases, the measures used should be the least restrictive possible, with the shortest possible duration, in accordance with hospital protocol, and they must be monitored. Such monitoring should prevent abuse, facilitate the use of alternative measures and ultimately help to reduce the use of control measures.

Documenting the application of coercive measures should ideally involve fieldwork (Bernheim, 2020; McCabe & Holmes, 2009), including observations and interviews in hospitals and courthouses, which I have conducted on a few occasions. Clearly, however, such access is complicated, even impossible, in times of a pandemic. Consequently, I conducted document research using three bodies of documents.[4] First, I searched legal and non-legal documents

[4] As official Quebec documents, court rulings and newspaper articles are mostly in French; quotes are generally my own translation.

produced by the Quebec government: decrees and orders; administrative directives issued by the Ministry of Health and Social Services and the Ministry of Justice, the Quebec National Institute of Public Health and the General Direction of Mental Health and Forensic Psychiatry[5]; and publications from the National Institute for Excellence in Health and Social Services. The second body of materials included documents that allow one to gather information about legal and hospital practice: case law—subject to availability in legal databases,[6] as most decisions are delivered from the bench or are not published—and newspaper articles.[7] This document research was supplemented by information obtained from advocacy groups and defense lawyers practicing in the judicial district of Montreal. Third, I reviewed the scientific literature on COVID-19 and mental health, which puts into perspective the regulatory choices of the Quebec government.[8]

Quebec's Regulation of the COVID-19 Pandemic and Mental Health: The Risk-based Approach

On March 13, 2020, the government issued its first decree, declaring that the Ministry of Health and Social Services could take any "measure required to ensure that the health and social services system has the necessary human resources" to operate (Government of Quebec, 2020a: 3). A week later, on March 20, a second decree forbade any indoor or outdoor gatherings with the exception of

[5] Which is officially called "Direction générale adjointe des services de santé mentale et de psychiatrie légale".

[6] Research was conducted on CanLII and SOQUIJ databases to find the trial court and court of appeal rulings, without date filter and with the following keywords : "*garde provisoire*" or "*évaluation psychiatrique*" or "*garde en établissement*" or "*autorisation de soin*" or "*autorisation de traitement*" or "*ordonnance de soins*" or "*ordonnance de traitement*" and "COVID" or "*pandémie*"; "psychiatric assessment" or "confinement in an institution" or "authorization of care" or "authorization of treatment" or "care order" or "treatment order" or "authorization to administer a Care Plan" and "COVID" or "pandemic." On November 19, 2020, 45 court rulings were identified: 12 for psychiatric assessment, 3 for involuntary admission and 30 for forced treatment, all from initial trial.

[7] Research was conducted on the websites of the main Quebec newspapers and television channels (Le Devoir, La Presse, Montreal Gazette, Le Journal de Montréal, Le Journal de Québec, le Soleil, Radio-Canada, CTV and CBC) for a result of 15 relevant articles.

[8] Research was conducted on PubMed with the keywords "mental health" or "psychiatry" and "COVID" or "pandemic," which resulted in 38 relevant papers (many articles not taken into account in this analysis deal with the epidemic of mental disorders associated with COVID-19).

situations related to work, services or transport (Government of Quebec, 2020b). In accordance with section 139 of the *Public Health Act*, a violation of ministerial decrees and orders is liable to fines of $1,000 to $6,000. Municipal and provincial police were immediately authorized to issue fines in the amount of $1,546 to enforce confinement and distancing measures. In early April, the Ministry of Health and Social Services issued an order allowing the National Director of Public Health to order individual confinement up to 14 days without a court decision (Order 2020-015).

Since the declaration of the public emergency, regular judicial activities have been suspended with the exception of urgent applications like *habeas corpus*, psychiatric assessment, involuntary admission and forced treatment. Notification formerly done by a bailiff can now be done by technological tools; all hearings must proceed behind closed doors; access to courthouses is allowed only to people whose presence is essential, and time limits are suspended in penal, civil and administrative matters (Ministry of Justice, 2020a, 2020b, 2020c; Order 2020-4251; Order 2020-4267). Concerning psychiatric procedures, facilities allowing video-hearing procedures must be provided, and judges have to decide if they want to see defendants in person or by videoconference. Defendants' rights are fully maintained: they must be notified, and they have the right to counsel and to appear before the court (General Direction of Mental Health and Forensic Psychiatry, 2020e).

Since mid-March, hospitalizations have been restricted to emergencies, and some hospitals have been designated specifically to treat COVID-19 patients. In psychiatry, the General Direction of Mental Health and Forensic Psychiatry (2020b, p. 1) produced a directive prioritizing interventions "that will limit hospitalizations," like telephone follow-ups. The use of emergency rooms was reduced to situations where "no alternative measure is possible" (General Direction of Mental Health and Forensic Psychiatry, 2020c, p. 2).

In psychiatric hospitals or psychiatric departments in general hospitals, patients diagnosed with COVID-19 who display symptoms have to be transferred regardless of their will to designated hospitals, and patients diagnosed with COVID-19 who do not have symptoms

have to be put in isolation. Directives for psychiatric emergency rooms and hospital units mandate the use of seclusion for inpatients who are "unable to comply with infection prevention measures" (General Direction of Mental Health and Forensic Psychiatry, 2020d, p. 5). The General Direction of Mental Health and Forensic Psychiatry (2020d, p. 6) considers that the situation of an inpatient who does not "collaborate" can represent an "imminent risk to the person or to others," and justifies seclusion. This interpretation of the kind of situation that poses an "imminent risk" is new and broader than the prior interpretation. The imminent risk justifying the use of seclusion requires an urgent and timely intervention and involves a threat to physical integrity. And most importantly, seclusion is an exceptional measure that must end as soon as possible. This new interpretation suggests, on the contrary, that seclusion can be applied, in the context of potential risk, for an indefinite period.

In psychiatric hospitals, group homes and assisted-living environments, "social distancing" measures have to be enforced for staff and inpatients (Ministry of Health and Social Services, 2020b; Quebec National Institute of Public Health, 2020). Visits, outings and temporary leaves are prohibited, except for "humanitarian purposes or to obtain essential treatment or services" and "supervised outdoor walks" (General Direction of Mental Health and Forensic Psychiatry, 2020a; Ministry of Health and Social Services, 2020a). There must be access to technology so that communication between patients and their families and friends can be possible (National Institute for Excellence in Health and Social Services, 2020a, p. 3).

At the end of March 2020, the National Institute for Excellence in Health and Social Services produced, at the request of the Quebec government, a literature review on the effects of the reduction in the number of psychiatric beds on the continuity of care. The mission of the Institute is "to promote clinical excellence," as well as "preparing recommendations and developing clinical practice guides to ensure optimal use of the technologies, medications and interventions used in health care and personal social service" (*Act respecting the Institut national d'excellence en santé et en services sociaux*, sections 4 and 5(2)). According to the document, special precautions must be taken with people with mental illness due to their "difficulty accepting and

respecting sanitary measures," particularly psychotic patients who have possibly a "poor understanding of protective measures" (National Institute for Excellence in Health and Social Services, 2020b, p. 6). However, the scientific literature presents a diversity of proposals that are not reflected either in this literature review or in official Quebec documentation.

While it is true that the risk of contamination is higher in people with mental illness than in the general population (Kozloff et al., 2020), particularly for patients with schizophrenia, the explanations differ greatly. For some, the difference is due to the fact that people with mental illness find it difficult to understand and respect anti-COVID measures (Fonseca et al., 2020; Kozloff et al., 2020). For others, discrimination associated with mental illness in the health and social services system and living conditions that make social distancing impossible, such as homelessness, no access to basic hygiene supplies, substance abuse and the conditions in some housing units, explain the difference (Shalev & Shapiro, 2020; Tsai & Wilson, 2020; Yao, Chen & Xu, 2020). For inpatients in particular, the obligation to stay in closed wards and the particular settings of those wards—the fact that staff and patients do not wear protective gear and that communal telephones must be used due to cell phone bans—are to blame (Li & Zhang, 2020; Miller, 2020).

Similarly, there are differing perspectives on how to manage this risk. Some adopt a risk-based approach. Fonseca et al. (2020), for example, go so far as to recommend that "schizophrenia patients should follow the same health instructions (e.g., influenza vaccine—unless specific restrictions apply) and receive the same treatment as clinical high-risk groups for COVID-19," including quarantine and isolation (p. 237). Psychiatric wards are not equipped for isolation against infection (Zhu et al., 2020), so isolation results in the use of seclusion. On the contrary, others state that coercive measures such as involuntary admission should be reserved for individuals with COVID-19 who do not follow the sanitary measures or for healthy individuals who are around people with COVID-19 (Strous & Gold, 2020). They propose a non-discriminatory, empathetic and holistic approach, suggesting action at political, systemic and individual levels, such as strengthening mental health care systems, expanding

mental health care policies, empowering mental health clinicians, promoting multidisciplinary teamwork and supporting patients (Boland & Dratcu, 2020; Druss, 2020; Pfefferbaum and North, 2020). From this perspective, strengthening out-of-hospital care could prevent COVID-19 infections, psychiatric crises and hospitalization (Garriga et al., 2020; Vieta, Perez & Arango, 2020). When hospitalization is necessary, different measures are suggested: document the needs of patients and their families in order to provide adequate services; promote communication with loved ones and maintain some in-person services (Li & Zhang, 2020).

Quebec's Regulation of the COVID-19 Pandemic and Mental Health: Risk-based Approach Put Into Practice

The Canadian Civil Liberties Association (2020) reports that 77% of the 10,000 tickets related to COVID-19 issued between April 1 and June 15 in Canada were issued in Quebec, particularly to homeless people, but also to people with mental illness who were sometimes known by the police (Hachey, 2020). The documentation of practices demonstrates a new judicial interpretation of risk with respect to psychiatric assessment, involuntary admission and forced treatment, consistent with that promoted by the Ministry of Health and Social Services regarding seclusion. It also demonstrates the subordination of the law and justice system to bureaucratic imperatives, at the cost of the rights of people with mental illness.

A Far-reaching Interpretation of Risk

Two weeks after the declaration of the state of emergency,[9] psychiatric assessment, involuntary admission and forced treatment applications invoking COVID-19 began to be filed by hospitals and almost systematically granted by courts.[10] These applications related to people suffering from psychotic disorders or intellectual disabilities, but also to seniors with cognitive impairment. The people in question deny the existence of COVID-19, have "delirious ideas in

[9] At least according to the decisions available on legal databases.
[10] With the exception of *Centre intégré de santé et de services sociaux de la Montérégie-Centre c LB*, 2020 and *Centre intégré universitaire de santé et de services sociaux du Nord-de-l'Île-de-Montréal c HD*, 2020.

particular in connection with COVID-19" (*Centre intégré de santé et de services sociaux du Bas-Saint-Laurent c SC*, 2020: § 7), do not apply anti-COVID measures or suffer from being confined for weeks at home. They were not infected.

Various situations were recounted in the judgments, such as an "episode of wandering by the defendant during which he could place himself in a situation of potential contagion" (*Centre intégré de santé et de services sociaux de la Montérégie-Centre c VA*, 2020: § 23), an attempt to cross the Canada-U.S. border, a visit to the supermarket or a refusal to wash hands. Relatives and doctors said they were not sure that defendants would obey and apply the anti-COVID measures, either because they did not understand them or because they did not agree with them. The living environment of defendants is sometimes presented as a risk of contagion because of proximity with others, lack of hygiene or homelessness. These situations constitute one of the motivations for a hospital's application.

It is in this context that risk is discussed. Risk is sometimes mentioned in the motions by the hospitals who claim that defendants are at risk of contracting and transmitting COVID-19. Courts discuss the risk of the alleged behaviour and consider potential exposure to COVID-19 as a sufficient risk to justify the hospitals' requests, thus breaking with legislative and jurisprudential prescriptions. The issue of risk is discussed in the same way for psychiatric assessment, involuntary admission and forced treatment, even though risk is not a criterion for any of these three mechanisms. This pandemic interpretation of risk is contrary to usual practices in the field; it raises several questions, especially in a context where ordering confinement—to contain the spread of COVID-19—without court approval is possible with more flexible substantive and procedural requirements. The risk referred to here is by no means a state of actual or potential danger, threat to the community or violence. Rather, it is, as Nikolas Rose (1996) says, the failure of certain individuals to govern themselves in a context where social and health norms are profoundly modified. The courts do not, however, consider in their reasoning the contexts in which defendants live, which the literature reports as one of the most important explanations for the risk of contagion for people living with mental illness. Nor do they

consider the context prevailing in health care facilities where staff and resources are lacking. Overall, considering the risk of contracting the virus as justifying, at least in part, an order for psychiatric assessment, involuntary admission or forced treatment, is a conceptual shift, with all that this implies in terms of indeterminacy and normative judgment. In a context where those affected by that kind of order are certainly not the only ones failing to comply with anti-COVID measures, these legal arguments suggest a particularly discriminatory approach for people with mental illness.

The Subordination of the Law and Justice System to Bureaucratic Imperatives

Due to the pandemic and the ensuing official guidelines, hearings are held by telephone or videoconference. The defendants, who are in a hospital, meet their lawyers, who are in the courthouse, at a distance. Courts generally consider that this procedure enables the defendants to present a full and complete defense,[11] a vision that is not shared by all. Advocacy groups and academics expressed concerns through open letters in newspapers, deploring the lack of support for defendants, asserting that organizational benefits relate primarily to the health and justice systems and claiming that the race for efficiency could be at the expense of the rights of people with mental illness (Bernheim & Pariseau-Legault, 2020; Provencher, 2020a). The case law seems to prove them right, since serious procedural breaches are justified by constraints of a practical nature in hospitals. For example, courts agree to dispense with notification and testimony and to allow shortened legal time limits for reasons such as limiting total hospitalization time, but also to avoid the long disinfection processes and more generally due to the lack of hospital resources.

Concerning notification, it is accepted that personal notification by the bailiff is not possible due to the COVID-19 pandemic. Notification could be done by technological means, but inpatients usually do not have access to cell phones or computers. In this context, some judgments allow notification to be delivered directly

[11] Although they may require defendants to attend courthouse when they have hearing problems or difficulty expressing themselves.

by medical staff. According to a court decision, defendants can sign the bail notification without actually receiving it. In one case, the lack of satisfactory proof of notification led the court to conclude that an exemption of notification is "the only remedy available for the hospital to hope to obtain a court order for psychiatric assessment" (*Centre intégré de santé et de services sociaux de la Montérégie-Centre (Hôpital Charles-Lemoyne) c JS*, 2020: § 26). In practical terms, lack of notification means that defendants do not know that proceedings are being brought against them. They therefore cannot contact a lawyer, prepare a defense or participate in the legal proceedings. Consequently, courts proceed *ex parte* on applications concerning freedom, integrity and self-determination.

In the case of a defendant who is suspected of having COVID-19 and placed in seclusion, the hospital argues that providing access to a telephone or videoconferencing would require sanitizing "with extreme aseptic standards" and that it does not have the staff and resources to do so (*Centre intégré de santé et de services sociaux de la Montérégie-Centre (Hôpital Charles-Lemoyne) c JS*, 2020: § 20). The court accepts this argument that there is a risk that the defendant could transmit the virus, even if it is not confirmed at the time of the hearing that the defendant has COVID-19. The court thus agrees to compromise the procedural guarantees for bureaucratic reasons unrelated to the mental state or behaviour of the defendant.

The lawyers I spoke with reported difficulties in trying to communicate with their hospitalized clients. For inpatients involved in legal proceedings, who do have access to hearings held by telephone or videoconference, the inability to consult with their lawyers means a practical inability to have the procedure explained and to prepare a defense. Their appearance in this context often falls short of normal standards of dignity, especially since some of them appear in a hospital gown.

To control contagion, it appears that some hospitals do not give access to telephones, which means that inpatients are prevented from communicating not just with lawyers, but also with advocacy groups and loved ones. Similarly, visits and outings, including on balconies or on the grounds of the hospital, are prohibited. The same situation

is reported in group homes and assisted-living environments. The reason given for these rules is the fear that inpatients or residents will not apply distancing measures, but also the lack of staff to monitor and control (Boutros, 2020).

The inability of inpatients and residents to communicate with the outside explains the lack of information we have on the situation. Some journalists, however, did investigate and uncover worrying situations that were confirmed by advocacy groups (Provencher, 2020b). Inpatients with COVID-19, as well as inpatients who were awaiting test results, have been secluded in rooms for up to 14 days without television, internet, running water or toilets, with "only a basin with a plastic bag" (Ducas, 2020). Patients who are considered unable to follow anti-COVID measures have been secluded in small rooms for months. While the deconfinement measures were gradually being put in place starting in mid-May 2020 in Quebec, visits and outings for inpatients and residents were still prohibited at the beginning of July (Loiseau, 2020). At the end of November 2020, in the midst of the second wave, it appears that practices differed greatly from one facility to another. Advocacy groups tried in vain to get information. Families of inpatients and residents reported that they were worried, and that the condition of their loved one was deteriorating (Duchaine, 2020). This situation led to tension in hospital units, a 30% increase in assaults and crises (Loiseau, 2020) and the regular use of chemical restraints (Braun, 2020).

The risk-based approach in times of a pandemic requires anticipating and managing an invisible and unmeasurable risk such as the possibility of catching and then transmitting COVID-19. In a largely underfunded health care system driven by efficiency goals, the management of this risk depends on bureaucratic requirements and the instrumentalization of the law for purposes of control. The indignity of living conditions in hospitals, group homes and assisted-living environments, the reinterpretation of legislative provisions concerning coercive measures and the subordination of the courts to the imperatives of managing an invisible and unmeasurable risk all confirm the punitive turn of Quebec's psychiatric policies.

Conclusion—Equality and Justice in Mental Health: Addressing Power Relations

The path taken by the Quebec government, hospital administrations and courts is based on the idea that people with mental illness present a potential risk due to a possible misunderstanding of confinement and social distancing measures. This risk-based approach not only breaks with previous legal interpretations but also turns out to be punitive and discriminatory: there is a noticeable difference between the treatment of the general population and of patients hospitalized for physical problems, including COVID-19, and the treatment of people with mental illness. While deconfinement started in May 2020, and non-psychiatric inpatients are discharged as soon as possible, psychiatric inpatients and residents in group homes and assisted-living facilities have remained deprived of visits and outings for months. Not only is the risk they pose not clear, particularly when the population of Quebec as a whole is deconfined, but this approach is also scientifically and legally questionable, going against basic care principles, as well as civil and fundamental rights.

A risk-based approach, which is not new in mental health,[12] facilitates, on one hand, the exclusion of people from decisions that affect them, and, on the other hand, the application of discriminatory treatment based on security and administrative considerations. This study of Quebec's regulation of mental health care in the context of the COVID-19 pandemic highlights how indeterminate legal concepts, such as risk, danger and incapacity, presented as tools of rights in a rights-based approach, can easily become tools of discrimination in a risk-based approach. Due to the indeterminacy of these concepts, wide discretion is left to the bureaucrats, psychiatrists, nurses, lawyers or judges, who will have to interpret them. These concepts constitute in this sense a constant threat to the rights of mental health patients, which materializes in three ways. First, indeterminate concepts can easily be influenced by stigmas around mental illness, especially since danger and incapacity to understand information and make decisions constitute common

[12] The presumed danger of mental illness has been the criterion for involuntary hospitalization in multiple jurisdictions since the nineteenth century and in Quebec since 1851.

prejudices associated with mental illness. Second, indeterminate concepts barely allow for the development of practical decision-making tools and favour context-dependent interpretations. Thus, even if a strict interpretation of a concepts is common, it can easily be overruled to achieve completely different goals. Third, in the interpretation process, clinical and social—but also administrative—considerations can easily take precedence over rights, even before courts, especially when safety is at stake.

In light of this analysis, it is clear that the law and courts are obviously not the allegedly infallible safeguards of rights in mental health that they are assumed to be. While Quebec law appears to be rights-based, the pandemic has highlighted the fragility and the reversibility of the progress made on this front. It seems clear that mental health law practices depend on contexts, constraints and power relations more than on formally recognized rights. The recognition of rights does not change the fact that individuals who disturb and frighten are excluded from discussions that concern them, while other socially valued groups are not only heard, but enjoy significant discretion in the exercise of their decision-making power, a situation that has endured for centuries (Foucault, 1999, 2003). Equality and justice for people with mental illness depend largely on the awareness of the power relations at work in the smallest corners of society—and on the collective decision to rebalance them—rather than on law, rights or courts. Equality and justice are then made possible by valuing and considering lived experience, recognizing systemic discrimination and neglect and making a massive investment in health care and social services. Only such social measures could reverse the punitive turn that is underway in Quebec's psychiatric policies.

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